The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

DAVID BROWN

AGED 46

WHILST IN THE CUSTODY OF MAGHABERRY PRISON

ON 15th DECEMBER 2012

[22nd July 2014]

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Glossary

CCTV	Close Circuit Television
CJI	Criminal Justice Inspectorate
CPR	Cardiopulmonary Resuscitation
ECR	Emergency Control Room
EMIS	Egton Medical Information System
HMIP	Her Majesty's Inspectorate of Prisons
NIPS	Northern Ireland Prison Service
PRISM	Prisoner Record Information System Management
PSST	Prisoner Safety and Support Team
PSNI	Police Service of Northern Ireland
SEHSCT	South Eastern Health and Social Care Trust

PREFACE

As Prisoner Ombudsman for Northern Ireland I have responsibility for investigating all deaths in prison custody in Northern Ireland. My investigators and I are completely independent of the Northern Ireland Prison Service (NIPS). Our Terms of Reference are available at www.niprisonerombudsman.com/index.php/publications.

I make recommendations for improvement where appropriate; and my investigation reports are published subject to consent of the next of kin in order that investigation findings and recommendations are disseminated in the interest of transparency, and to promote best practice in the care of prisoners.

Objectives

The objectives for Prisoner Ombudsman investigations of deaths in custody are to:

- establish the circumstances and events surrounding the death, including the care provided by the NIPS;
- examine any relevant healthcare issues and assess the clinical care provided by the South Eastern Health and Social Care Trust (SEHSCT);
- examine whether any changes in NIPS or SEHSCT operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of all prison records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. Where necessary, independent clinical reviews of the medical care provided to the prisoner are commissioned. In this case, Miss Helen Fernandes, Consultant Neurosurgeon at

Addenbrookes Hospital, Cambridge undertook a clinical review of the healthcare provided to Mr Brown in connection with the circumstances which led to his demise. Professor David Taylor, Director of Pharmacy and Pathology at The Maudsley Hospital, London also provided expert opinion in relation to the toxicology findings.

This report is structured to outline the cause of Mr Brown's death and NIPS handling of the incident.

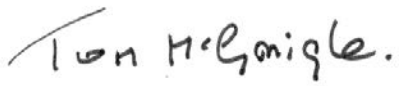
Family Liaison

Liaison with the deceased's family is a very important aspect of the Prisoner Ombudsman's role when investigating a death in custody. My predecessor first met with Mr Brown's next of kin in January 2013, and contact has been maintained with them throughout the investigation.

Although this report will inform several interested parties, it is written primarily with Mr Brown's family in mind.

I am grateful to Mr Brown's family, the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and the clinical reviewers for their contributions to this investigation.

I offer my sincere condolences to Mr Brown's family for their sad loss.



TOM McGONIGLE
Prisoner Ombudsman for Northern Ireland
22nd July 2014

SUMMARY

Mr Brown died in an outside hospital on 15th December 2012 from a brain haemorrhage, whilst in the custody of Maghaberry Prison. Although he had a severe pre-existing heart disease, a pathologist concluded it was highly unlikely to have played a role in his death.

Toxicology tests revealed the painkilling drugs codeine and tramadol, which were prescribed to him, were present in his system at concentrations that lay within their respective therapeutic ranges. No other common drugs were detected. This is important as there was considerable speculation, including in the media, about a white powdery substance that was found around Mr Brown's nose at the time of his death. It was not possible to establish what this powdery substance was.

When Mr Brown was discovered in an unresponsive state, slumped off the side of the toilet in his cell, the NIPS staff response was inadequate. The two officers involved had only been out of training for four weeks. While both said that they had not been trained in how to deal with this type of incident, the NIPS Training Department flatly contradicted this assertion.

There were a series of inactions that indicated failure to recognise the gravity of the situation:

- Mr Brown was left unattended for five minutes, with his cell door open;
- The alarm was not immediately raised. This meant the nurse faced unnecessary delays in getting through grilles to reach the landing and further medical support was delayed;
- The nurse was not made aware that it was an emergency situation;
- It took seven minutes before the senior officer was informed of this incident; and
- Other prisoners were not locked. Some of them entered Mr Brown's cell for brief periods during this time, which meant his dignity was infringed.

Mr Brown had been complaining of headaches before he died, and was first seen by Healthcare staff on 23rd November. He saw doctors twice in relation to this complaint, and on 13th December gave the impression that the headaches had settled, and that he was not too worried about them. Our clinical reviewer was not critical of his medical management at the prison, and did not feel that an opportunity to achieve an earlier diagnosis existed, or that there would have been a possibility to achieve an alternative outcome for Mr Brown.

This investigation has identified four matters requiring improvement, two of which (NIPS Recommendation 3 and the SEHSCT recommendation) were previously made following death in custody investigations, and accepted by the NIPS and the SEHSCT.

RECOMMENDATIONS

NIPS -

1. **Incident Handling Training** – The NIPS should ensure that all its new recruits are able to identify potential emergencies, and act swiftly and appropriately upon them. (Pages 14-17)

2. **Governor's Order Regarding Medical Emergencies** – Clear instructions should be produced to determine what actions are to be taken when a prisoner has been found in an unresponsive/unconscious state. (Pages 16-17)

3. **Post-Incident Support** – The NIPS should ensure meaningful support is provided to staff following every death in custody. (Page 19)

SEHSCT –

1. **EMIS[1] Records** - In line with the Northern Ireland Practice and Education Council for Nursing and Midwifery 'Standards for Record Keeping,' entries to medical records should contain details of all assessments, observations, reviews and actions undertaken by healthcare staff. (Pages 17-18)

NIPS & SEHSCT RESPONSE

The NIPS responded to this report by saying that they have accepted their recommendations and have drawn up an action plan for their delivery.

The SEHSCT also accepted the recommendation made for them and have advised that it will be considered at the Lessons Learned Group Meetings, and has been reiterated to their staff.

[1] EMIS – Egton Medical Information System. The electronic database used by Prison Healthcare to store prisoners medical records.

MAGHBERRY PRISON

Maghaberry is a high security prison which holds male adult sentenced and remand prisoners. It was opened in 1987.

There have been three deaths in Maghaberry since Mr Brown died. One of these deaths appears to have been self-inflicted, and two appear to have been natural causes.

Maghaberry established a Prisoner Support and Safety Team (PSST) in 2011. The team comprises a governor and five members of staff. They have several responsibilities including their role to support prisoners who are identified as vulnerable. Mr Brown was not engaged with PSST at the time of his death.

The last CJI/HMI Prisons inspection of Maghaberry was conducted in March 2012 and published on 17th December 2012. Several of the 93 recommendations in that report are relevant to the care of vulnerable prisoners.

Maghaberry has an Independent Monitoring Board (IMB) whose role is to observe all aspects of the prison regime. The 2012-13 IMB annual report did not make any recommendations that are relevant to Mr Brown's death.

FINDINGS

SECTION 1: CAUSE OF DEATH

On the morning of 14th December 2012 staff found Mr Brown in an unresponsive state. Medical assistance was obtained and at 11.00 he was transferred to outside hospital.

On 15th December 2012 Mr Brown was diagnosed as being brain-stem dead having suffered a brain haemorrhage and died once life support was no longer provided.

The autopsy report recorded Mr Brown's death as having been caused by an *"Intracerebral Haemorrhage due to the rupture of a berry aneurysm of the right middle cerebral artery."* A Neuropathology report by Dr B Herron which was referred to in the autopsy concluded:

"In summary the features are of a ruptured berry aneurysm of the right middle cerebral artery that has ruptured intraparenchymally (bled into the tissue of the brain)*. This is not an unusual finding for these aneurysms. The size of the haematoma suggests that he would have been severely compromised clinically following this acute rupture. There is evidence of previous leakage surrounding the haematoma but no large previous haemorrhage. The ruptured Berry aneurysm and associated haematoma have led to cerebral oedema and cerebral perfusion failure. This ruptured aneurysm and associated haematoma are sufficient to be considered the cause of death."*

The autopsy also revealed severe pre-existing heart disease in the form of marked narrowing of one of the main coronary arteries due to a severe degenerative process (coronary artery atheroma). This is a common cause of heart attacks and on its own a very common cause of sudden death. The pathologist, Dr Bentley concluded however, that in this instance, in view of the presence of an intracerebral haemorrhage, it was highly unlikely that heart disease played a role in Mr Brown's death.

Toxicological analysis of a sample of blood taken in hospital revealed the presence of the analgesic (painkilling) drugs codeine and tramadol, at concentrations that lay within their respective therapeutic ranges. No other common drugs were detected.

Mr Brown was prescribed codeine and tramadol in prison. The nurse and paramedics, who attended him when he was found in a collapsed state, indicated that there was a white powdery substance around Mr Brown's nose. It was not possible to establish what this substance was, due to the time the blood sample was

taken and the various half-lives[2] of different substances. A prisoner said that Mr Brown had been sniffing codeine, but no further witness accounts or evidence corroborated this.

In considering the amount of codeine and tramadol found in Mr Brown's blood post-mortem, Professor David Taylor advised that codeine and tramadol can be absorbed intranasally, but the use of crushed tablets in the form prescribed may not have given rise to effective plasma levels. He continued by saying that the detection of these two drugs at post-mortem suggested prior use by some route but was consistent with the taking of medications as prescribed. He added that to his knowledge, neither the use of codeine nor tramadol is associated with the risk of cerebral aneurysm.

The Consultant Neurosurgeon, Miss Helen Fernandes stated in her clinical review report that *"intracranial aneurysms arise as a result of atheromatous change in the arteries* (narrowing of the arteries) *that supply the brain. This leads to the degradation of the linings of the blood vessels and in time, at pressure points, weaknesses or aneurysms develop. These are prone to spontaneous, unprovoked rupture. The mortality and morbidity from this condition is very high, particularly in the setting of a large intracerebral haematoma, which causes immediate deleterious* (harmful) *effects on the brain."*

She stated that at the moment of rupture, and with the findings of the nurse and paramedics who attended it was clear to her that this event was *"unsurvivable."*

[2] The half-life of a substance refers to the time it takes for its properties to halve once consumed.

SECTION 2: MR BROWN'S COMPLAINTS ABOUT HEADACHES

Mr Brown's family were concerned that he had been complaining of a bad headache, and requesting to see a doctor for a number of weeks prior to his death, but said this had not been granted.

Accounts from five prisoners concur: they said Mr Brown had been complaining of a pain in his head, and more specifically behind one of his eyes. Their versions of the duration of this pain ranged from one week to three months. Some accounts suggested that he had been seeking alternative pain relieving medication from other prisoners during his last week.

Another prisoner who said he was in Mr Brown's cell every night explained that he would hold his head and complain sorely about his headache. When he suggested Mr Brown should go to the doctor, Mr Brown suggested it would be pointless as he was already on painkillers.

None of the landing staff we interviewed were aware of Mr Brown's medical concerns. They said he would not have shared this level of information with them, and advised that Mr Brown would have had limited interaction with officers; and that unless a prisoner proactively raised their medical complaints, prison officers would not be informed of prisoner's medical concerns due to confidentiality.

Mr Brown's prison medical records show that he was first seen in relation to his headache on 23rd November 2012. The EMIS[3] appointment book states that he had a pain behind his right eye and that he was booked into the next doctor's clinic scheduled for 29th November.

Mr Brown had a visit on the morning of 29th November and did not attend his doctor's appointment. It was rescheduled for the next doctor's clinic on 3rd December.

The first time Mr Brown was recorded mentioning the pain in his head was during a phone call on 1st December 2012. He referred to a pain behind his eye when he coughed, and said that a nurse he had spoken to about it the previous week had not put him on the doctor's list. However as detailed above, this was not the case, as Mr Brown had been offered a doctor's appointment but chose to attend a visit instead. During the same phone conversation he also stated that the pain when he coughed had only been happening since the previous Thursday (29th November 2012).

At his appointment on 3rd December the doctor recorded that Mr Brown was complaining of headaches, that he checked his blood pressure and that there were

[3] EMIS – Egton Medical Information System. The electronic database used by Prison Healthcare to store prisoners medical records.

no neurological symptoms. He noted that Mr Brown was already on pain relieving medication, queried whether he was suffering from a tension headache, and indicated it should be reviewed if it did not settle.

In a phone call later that day Mr Brown sounded frustrated with this outcome because the doctor had referred to his complaint as a headache rather than a throbbing pain behind his eye. He said that the doctor mentioned he would have normally prescribed paracetamol in the first instance, but because the medication he was on already contained paracetamol, he felt this should sort out the problem.

On 6th December Mr Brown saw the nurse regarding his headaches. The nurse listed him to see the doctor again on the morning of 13th December 2012.

Mr Brown saw the doctor on 13th December. The medical record reported he had been experiencing pain behind his right eye for one week, and that it was worse on coughing. It was also recorded that this pain had completely settled, and that the situation was to be reviewed as necessary. The doctor said that Mr Brown gave him the impression that the headaches had settled, that he did not feel too worried about it, and that he had only attended the appointment so that he would not get into trouble for missing it.

A prisoner who was friendly with Mr Brown provided a timeline commencing 7th November 2012, of when these headaches symptoms started to occur. Despite it being written in retrospect the prisoner highlighted that there was around a ten day period from 3rd December where the headaches *"seemed to go away."* There are however some inconsistencies in this timeline - for example this prisoner recorded that Mr Brown spoke with him on 14th December 2012, and told him the pain in his head scored 9/10, whereas CCTV footage and the events that unfolded on the morning of 14th December show this conversation did not occur, as Mr Brown suffered his ruptured aneurysm that morning.

The process for a prisoner getting to see a doctor is that a medical request is first placed on PRISM[4] by landing staff. This is then picked up by the house nurse who triages the prisoner. If triage confirms a doctor's appointment is required, the nurse places it on the EMIS appointment book. In some instances landing staff would phone the nurse to notify them of a prisoner's request, rather than entering it on PRISM. On these occasions no records are made.

Printouts of Mr Brown's medical requests and EMIS appointments were obtained for the four months prior to his death. There is no evidence from either of these that requests from Mr Brown to see the doctor were overlooked. It is however not possible to conclude whether there were any requests made by phone call that were not followed up.

[4] PRISM – Prison Records Information Systems Management. The database used to store all details / records pertaining to each prisoner.

In her clinical review report, Miss Fernandes stated *"With the benefit of hindsight and with the knowledge gained from post mortem examination there is evidence that the aneurysm may have previously bled. The symptoms that Mr Brown experienced in late November/early December may have been secondary to expansion of the aneurysm and 'microhaemorrhage'* (small bleeds)*. There is no certainty to this as the symptoms in any event he experienced were not typical with an absence of neurological symptoms. I am therefore not critical of his medical management at the prison and do not feel that an opportunity to achieve an earlier diagnosis existed and as such as an opportunity to achieve an alternative outcome for Mr Brown."*

SECTION 3: NIPS HANDLING OF THE INCIDENT

Whilst earlier attendance by nurses or ambulance paramedics would have made no material difference to Mr Brown's demise, a review of the CCTV footage highlighted concerns that could be materially relevant for future medical emergencies.

The table below outlines the actions observed on the CCTV footage and associated concerns about how the incident was handled.

Time	Action Observed	Concern Y/N	Details
08.23	Officer A walked into Mr Brown's cell and left a carton of milk. He also briefly opened the observation flap into the cell toilet area.	No	The officer could not recall what he saw when he looked through the toilet observation flap, but surmised that he must not have seen anything that alarmed him. He also advised that prisoners often block this observation flap with toilet paper for privacy.
09.09	Officer B looked briefly into Mr Brown's cell and walked away.	No	The officer was calling Mr Brown to attend the nurse for his medication. He saw that Mr Brown was in the toilet cubicle, so allowed him his privacy and returned to the class officer's desk.
09.31	Officers A & B walked to Mr Brown's cell. Officer A entered the cell for a short period and Officer B remained at the door. Both then talked on the landing for 22 second before returning to the class officer's desk.	**Yes**	Both officers stated that while talking at the class officer's desk, Officer B mentioned that Mr Brown was on the toilet when he went to call him for his medication at 09.09. On hearing this, Officer A recalled that Mr Brown was on the toilet 46 minutes earlier and thought that this was strange, so they both went to his cell, where they found him slumped in an unresponsive state, positioned slightly off the side of the toilet. **It is concerning that an officer did not remain with Mr Brown following their discovery and that he was left for five minutes.**

Time	Action Observed	Concern Y/N	Details
09.32	Both officers walked back to the class officer's desk to contact the nurse.	**Yes**	Mr Brown was left unattended, the cell door was left open and other prisoners entered the cell for brief periods. **It is concerning that** • **the alarm was not raised;** • **Mr Brown was left unattended;** • **his dignity was infringed when prisoners entered his cell; and** • **other prisoners were not locked at this time.**
09.36	The nurse arrived on the landing and entered Mr Brown's cell – Officer A joined her in the cell.	**Yes**	The nurse was unaware that it was an emergency situation. **It is concerning that unnecessary delays were faced by the nurse in getting through the grills onto the landing because the emergency alarm had not been raised.**
09.38.15 09.38.44	Officer A left the cell and the nurse popped her head out. Officer A then made a call at the class officer's desk. Once finished on the phone Officer A returned to the cell. The nurse briefly popped her head out of the cell door again as if to ask Officer B to get something – he then went off camera.	**Yes**	The nurse said that she was tasking the officer to get more medical help and an ambulance. The officer said that he was calling for a second nurse to attend and after this he notified the senior officer of the incident. **It is concerning that** • **it took seven minutes before the senior officer was informed of this incident;** • **an ambulance was not tasked by the officer; and** • **there is no record on the ECR log that another nurse was tasked to the scene at this time.** The nurse was clarifying whether help was coming to move Mr Brown.
09.40	Officer B returned to the cell with blue aprons along with the senior officer and another landing officer. The senior officer went to the class officer's desk to use the phone.	No	Mr Brown was put in the recovery position shortly after this time by the three landing officers, under the nurse's instruction. At this point the senior officer believed he called an ambulance, but the ECR log does not corroborate this.

Time	Action Observed	Concern Y/N	Details
09.40 to 09.52 09.47	Activity of staff coming and going from Mr Brown's cell The senior officer again used the phone.	**Yes**	ECR log states the ambulance was requested by the SO at 09.49 which accords with CCTV analysis. The second nurse is recorded as having also been requested at this time. **The delay in requesting the ambulance and second nurse is concerning.**
09.52	A second nurse entered Mr Brown's cell. Subsequently only the two nurses remained with Mr Brown until the paramedics arrived.	**Yes**	**Had emergency procedures been instigated the second nurse would have known to attend the location straight away.**
09.53 09.55	The second nurse spoke to the senior officer at the class officer's desk. Second nurse seen using the phone.	**Yes**	**There are no details on EMIS to ascertain what involvement the second nurse had in this incident or who he was calling.**
10.12	Paramedics arrived on the landing.	No	
10.24	Paramedics took Mr Brown off the landing on a stretcher.	No	

The two officers who found Mr Brown in an unresponsive state were new recruits who had been out of training for four weeks, and had never dealt with an incident like this.

Both officers had received First Aid training. It stipulates that when a person is found unresponsive and breathing they should:

Try to get a response from the person; if no response

↓

Check for breathing. Where breathing is present place the casualty in the recovery position

↓

Where possible send someone to get emergency help.

The officers said they could see that Mr Brown was breathing when they first arrived in his cell. They did not place him in the recovery position at the earliest opportunity and left him for five minutes on his own until further help arrived. The explanation given by both officers was that they were in shock and they did not want to risk moving him until professional help arrived. With hindsight and added experience, both now appreciate that at least one of them should have stayed with Mr Brown, and that their response to this incident should have been handled differently.

Whilst there is no specific Governor's Order detailing what action should be taken in a medical emergency, Order 1-12 'Self Harm and Suicide Prevention' details actions to be taken in a similar situation i.e. when someone is unresponsive. It states that staff need to inform Healthcare staff of the circumstances and assess if there is any immediate action necessary to be taken to preserve life, and advises the following action:

1. Apply CPR procedures
2. Place prisoner in the recovery position

It is common NIPS practice when this type of incident is discovered to raise the "discipline alarm" by pressing an alarm button, of which there are several on the landing. This immediately alerts the senior officer to attend the location, and alerts other staff to lock all prisoners in their cells. It also accelerates the flow of information to the right people, such as Healthcare, and to the Emergency Control Room.

The nurse said that when she received the phone call to attend Mr Brown, she was not told that he was unresponsive or that it was an emergency situation – she was simply told that he *"was not well."* The officer's account differed. He said that he told the nurse Mr Brown was foaming at the mouth, and breathing but unresponsive. While experience led the nurse to take her emergency medical bags, as the alarm had not been raised, she encountered delays in getting through the grilles to the landing. If the alarm had been raised, the POD officer[5], who controls the grilles, would have known to ensure she was not delayed at the grilles.

On entering the cell the nurse found Mr Brown slumped down the side of the toilet with his knees slightly up and his chin touching his chest. Her main priority was to get him moved into the recovery position so that his airways were not compromised, but she needed additional help to move him. Throughout the time she was waiting for assistance she kept his head tilted back to ensure his airways remained open. The nurse said she felt extremely frustrated with the way the landing staff handled this incident.

The senior officer said that normally there would not be any delay in notifying the senior officer when this type of incident had occurred. However he recognised that it was new officers dealing with this type of incident for the first time. Both officers informed him they had been trained not to use the discipline alarm for a medical emergency. However due to the severity of the situation, he would have raised the discipline alarm so that appropriate personnel would have been alerted and the prisoners would have been locked down.

[5] The POD officer is located in the secure POD where all movement throughout the house is managed.

Nurse's Record Keeping

The Northern Ireland Practice and Education Council for Nursing and Midwifery 'Standards for Record Keeping' stipulates that entries to medical records must demonstrate details of all assessments, risk assessments and reviews undertaken, and provide clear evidence of the arrangements made for the patient. The second nurse who attended this incident did not make any record in Mr Brown's medical file.

The reason he gave was that the other nurse was carrying out the observations on Mr Brown and made the corresponding EMIS entry. He said it would have been duplication for him to record his involvement. However this nurse could not recall whether he was calling for an ambulance when using the phone at 09.55 at the class officer's desk – according to the account of the senior officer and ECR log the ambulance had already been called eight minutes earlier. In the absence of an EMIS entry, the nurse also had to purely rely on his memory when assisting this investigation, and was therefore uncertain in several of his responses. The South Eastern Health and Social Care Trust's internal review was consequently unaware of his attendance at the scene. In the case of a serious incident or death in custody it is not acceptable that a nurse who attended should fail to record their involvement and observations on EMIS.

SECTION 4: POST-INCIDENT ISSUES

Speculation around Mr Brown's Cause of Death

During interviews with prisoners and staff it was evident that speculation about the cause of Mr Brown's death was rife within the prison, and had been discussed with the press. Some such conversations went unchallenged when brought up in front of a senior officer. As noted on Pages 9-10 these rumours and subsequent media articles were unsubstantiated. They added to the distress of Mr Brown's family and friends.

Post-Incident Staff Support

Both of the officers who found Mr Brown in an unresponsive state were disappointed by the lack of post-incident support provided.

They received a generic e-mail that was sent to everyone involved, which reminded them of the availability of CareCall. The Personnel Governor came to the landing to check the journal for timings, and spoke to prisoners, but did not speak to them individually.

One of the officers said he was on the landing when a range of people (Chaplains, Counsellors, Governor's and Managers) arrived to speak to the prisoners in order to find out how they were coping after Mr Brown's death. He felt annoyed that all the support was for the prisoners, and that no one had asked him in person how he was coping, particularly because of the short time that he had been in the job. He was however fulsome in his praise for longer serving colleagues who spoke to him about the incident.